History and Physical – Rotation 4

Siddharth Shah
Rotation 4 – Ambulatory Care

Identifying Data

May 8th, 2023 – 9:00 AM
YN 13 M, Arabic, Hicksville, NY
Informant: Patient, reliable

Chief Complaint: Right pinky injury.

History of Present Illness:

13 y/o M with no PMHx BIB mother presents c/o right pinky injury for 1x day. Yesterday the patient was playing basketball at the school gym at 11:00 AM where he went to rebound the ball, and the ball directly hit the tip of his right 5th digit. The patient immediately felt throbbing pain and went to see the school nurse, where he was given an icepack, and went back to class, but still felt pain, and noticed bruising on the palmar side of his 5th digit. At home he applied ice pack on and off for 15 mins 3-5x times which helped with the swelling, and pain. Today morning the patient noticed the swelling was worse than yesterday, and there was more bruising prompting a visit to the urgent care today. The patient can move his pinky with limited ROM, and pain is noticeable when flexing the pinky (5/10) pain. The patient took Motrin last night which helped with the pain. The patient denies any weakness, numbness, and tingling to the 5th right digit, and denies any trauma to head or injury anywhere else. Patient is able move his other digits on right hand with ease and wrist as well.

Past Medical History:

- None

Past Surgical History:

- None

Medications:

- None

Allergies:

- NKA

Family History:

- Father 40, alive and well.
- Mother 35 alive, and well
- Sibling: 6-month sister alive, and well.

Social History:

- Living with mom, dad, and younger sister
- In 7th grade and performing well and no issues at school

Review of Systems:

General: Denies Fever, Fatigue, and chills

Skin: Denies changes in texture, excessive dryness or sweating, pigmentations, moles/rashes, or changes in hair distribution.

Head: Denies headache

Eyes: Denies visual disturbances, double vision, blurriness, excess tearing or dryness, photophobia, or pruritis.

Ears: Denies hearing loss, tinnitus, discharge, earache.

Nose and sinuses: Denies discharge, obstruction, allergies, or epistaxis

Mouth and throat: Denies sore throat, bleeding gums, ulcerations.

Neck: Denies localized swelling, lumps, stiffness, or decreased range of motion.

Pulmonary: Denies dyspnea. denies wheezing, or productive cough.

Cardiovascular: Denies palpations. Denies chest pain.

Gastrointestinal: Denies abdominal pain, vomiting, and diarrhea.

Genitourinary: Denies incontinence, dysuria, nocturia, urgency, oliguria, or polyuria.

Nervous: Denies episode of syncope

Musculoskeletal: **5th right finger digit limited ROM, swelling, pain, and bruising**

Endocrine: Denies heat/cold intolerance, excessive sweating.

Psychiatric: Denies anxiety. Negative history of depression. Denies having SI/HI

Physical Exam:

General: Appears in no acute distress, well groomed, appears stated age, slightly overweight

- BP(Seated) Left arm: 100/70
- P: 90 bpm, regular
- R: 16 breaths/min, unlabored
- T: 98.0 F oral
- O_2 Sat: 98 Room air
- Height: 5'1– Weight: 146 lb – BMI: 27.8

Skin: **Ecchymosis on palmar side of 5th right digit**. Warm & moist; good turgor; non-icteric; no rashes noted

Nails: No clubbing, capillary refill <2 seconds in all four extremities

Head: Normocephalic, atraumatic.

Eyes: No strabismus, sclera white, cornea clear, conjunctiva pink.

Ears: No masses, lesions, or deformities on external ears. No discharge or foreign bodies in external auditory canals AU. TM's white and intact with light reflex in good position AU.

Neck: Trachea midline. 2+ Carotid pulses, no stridor, thrills, or bruits noted bilaterally.

Thyroid: Nontender to palpation, no masses, no bruits noted.

Chest: Symmetrical, no deformities or trauma. Respirations unlabored, no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation throughout.

Lungs: Clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi.

Heart: Carotid pulses are 2+ bilaterally without bruits. RRR, S1 and S2 are distinct with no murmurs, S3 or S4.

Abdomen: Abdomen flat and symmetric, no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants. No tenderness, guarding or rebound noted.

Musculoskeletal: **No acute deformity noted. Ecchymosis discoloration noted on 5th right digit palmar surface. Tender to palpation on 5th right digit (give location). Limited ROM of 5th right digit. No edema**

Differential Diagnosis:

1. Non-displaced fracture of right 5th digit
2. Sprain to right 5th digit
3. Contusion to right 5th digit

Assessment: 13 y/o M with no PMHx BIB mother presents c/o right pinky injury for 1x day s/p playing basketball yesterday at the school gym. Pain is worse with flexion, and limited ROM. On physical exam No acute deformity noted. Ecchymosis discoloration noted on 5th right digit palmar surface. Tender to palpation on 5th right digit. Will order right hand x-ray to r/o fracture. X-ray reveals nondisplaced Salter 2 Fracture of the proximal end of right fifth middle phalanx. Will treat with ulnar gutter splint.

Work-up:

- X-ray of right hand

Diagnosis:

- **Impression from Radiologist: Nondisplaced Salter 2 Fracture of the proximal end of right fifth middle phalanx. No angulation. Growth plate is preserved.**

Plan:

- Apply ulnar gutter splint to immobilize 4th, and 5th right digit
- Pain: Ibuprofen PRN
- F/u with ortho within 48 hours
- ER precautions: Patient advised to go to ER if numbness, tingling, pallor, or loss of sensation occur.

Patient Education. You have a Non-displaced Salter 2 fracture. We will apply a ulnar gutter splint that should stay on for 4-6 weeks and follow up with orthopedics within 48 hours. Use Ibuprofen as needed. Patient is advised to not play any sports until fracture is healed.